



501 [c] 3 Non-Profit Organization

## APPLICATION FOR HAIR REPLACEMENT

Date: \_\_\_\_\_

Child's name: \_\_\_\_\_ Parent or Guardian Name: \_\_\_\_\_

Gender: Female / Male Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Hair Diagnosis: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

Have you ever received a hair replacement from us in the past? \_\_\_\_\_

If so, when? \_\_\_\_\_

Head size: \_\_\_\_\_ Color of Hair: \_\_\_\_\_

Length of Hair: Above Shoulder / Below Shoulder      Bangs: Yes / No

Doctors Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Social Worker's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Referred By: \_\_\_\_\_

Salon Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Mail this form **with a birth certificate and diagnosis on letterhead from doctor or hospital**. Custom replacements take up to 12 wks. For delivery. Hair replacement packages will be delivered to child's address, allow up to 3 wks. E-mail all information to [childrenwithhairloss@hotmail.com](mailto:childrenwithhairloss@hotmail.com) or send to:

Children with Hairloss, Inc.

12776 Dixie Hwy.

South Rockwood, Michigan 48179

(734) 379-4400

(734) 379-8983 FAX

1-888-4-KIDS-HAIR